



June 29, 2010

**TO:** Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

**FROM:** /Daniel R. Levinson/  
Inspector General

**SUBJECT:** Review of Inpatient Rehabilitation Facilities' Compliance With Medicare's  
Transfer Regulation During Fiscal Years 2004 Through 2007 (A-04-09-00059)

The attached final report provides the results of our review of inpatient rehabilitation facilities' compliance with Medicare's transfer regulation during fiscal years 2004 through 2007.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [Robert.Vito@oig.hhs.gov](mailto:Robert.Vito@oig.hhs.gov). Please refer to report number A-04-09-00059 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF INPATIENT  
REHABILITATION FACILITIES'  
COMPLIANCE WITH MEDICARE'S  
TRANSFER REGULATION DURING  
FISCAL YEARS 2004  
THROUGH 2007**



Daniel R. Levinson  
Inspector General

June 2010  
A-04-09-00059

# ***Office of Inspector General***

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

An inpatient rehabilitation facility (IRF) is a hospital or a subunit of a hospital whose primary purpose is to provide intensive rehabilitation services to its inpatient population. Under the Medicare prospective payment system for IRFs, the Centers for Medicare & Medicaid Services (CMS) classifies beneficiaries into 1 of 100 case-mix groups depending on their clinical characteristics and expected resource needs. CMS assigns each case-mix group a prospective payment rate and uses the rate to calculate the prospective payment. Fiscal intermediaries under contract with CMS process and pay Medicare claims submitted by IRFs.

Pursuant to Medicare's transfer regulation, Medicare pays the full prospective payment to an IRF that discharges a beneficiary to home. In contrast, Medicare pays a lesser amount, based on a per diem rate and the number of days that the beneficiary spent in the IRF, for a transfer case. A transfer case is defined as one in which (1) the beneficiary's IRF stay is shorter than the average stay for nontransfer cases in the case-mix group and (2) the beneficiary is transferred to another IRF; a short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments. Whether Medicare pays for a discharge to home or a transfer depends on the patient status code indicated on the IRF's claim.

Previous Office of Inspector General audits identified overpayments to transferring IRFs that did not comply with Medicare's transfer regulation. In response to our recommendations, CMS implemented an edit in the Common Working File (CWF) on April 1, 2007, to identify transfers improperly coded as discharges.

This audit covered 5,703 IRF claims totaling \$102.7 million that were paid during fiscal years 2004 through 2007. These claims had shorter than average stays, were coded as discharges to home or discharges to home with home health services, and pertained to beneficiaries who were admitted to another facility on the same day.

### **OBJECTIVES**

Our objectives were to determine whether (1) IRFs coded selected claims in compliance with Medicare's transfer regulation during fiscal years 2004 through 2007 and (2) the new CWF edit detected miscoded claims and fiscal intermediaries took appropriate action to adjust claims that the edit identified.

### **SUMMARY OF FINDINGS**

IRFs did not always code claims in compliance with Medicare's transfer regulation. Of the 220 claims in our sample, 7 claims paid after the CWF edit was implemented were not subject to the transfer regulation. The remaining 213 claims, which pertained to transfers to facilities that were subject to the transfer regulation, were improperly coded as discharges. These 213 claims resulted in overpayments of \$1,212,745. Based on our sample results, we estimated that fiscal intermediaries overpaid \$34,051,807 to IRFs for the 4-year period that ended September 30,

2007. IRFs generally attributed the miscoded claims to clerical errors and a lack of knowledge of where beneficiaries went after leaving their facilities.

Although the new CWF edit detected miscoded claims, fiscal intermediaries did not take appropriate action to adjust the claims and prevent incorrect payments. Of the 20 sampled claims that were paid after the CWF edit was implemented, 7 were not subject to Medicare's transfer regulation and 13 were incorrectly coded as discharges rather than transfers. The CWF edit detected all 13 incorrectly coded claims. However, fiscal intermediaries did not take action on the CWF edit alerts to prevent incorrect payments for these claims.

## **RECOMMENDATIONS**

We recommend that CMS:

- recover the \$1,212,745 in overpayments identified in our sample,
- instruct fiscal intermediaries to review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$32,839,062,
- instruct fiscal intermediaries to take appropriate action in response to future CWF edit alerts,
- follow up with fiscal intermediaries to ensure that they took appropriate action in response to CWF edit alerts, and
- consider reviewing claims paid after our audit period to identify any improperly coded transfers.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS agreed with our recommendations and described the corrective actions that it planned to take. CMS's comments are included in their entirety as Appendix C.

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## INTRODUCTION

### BACKGROUND

#### **Inpatient Rehabilitation Facilities**

An inpatient rehabilitation facility (IRF) is a hospital or a subunit of a hospital whose primary purpose is to provide intensive rehabilitation services to its inpatient population.

Section 1886(j) of the Social Security Act (the Act) established a Medicare prospective payment system for IRFs. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, began implementing the prospective payment system for cost-reporting periods beginning on or after January 1, 2002. Under the system, CMS classifies beneficiaries into 1 of 100 case-mix groups depending on their clinical characteristics and expected resource needs. CMS assigns each case-mix group a prospective payment rate and uses the rate to calculate the prospective payment.

During our audit period (fiscal years (FY) 2004 through 2007), CMS contracted with fiscal intermediaries to process and pay Medicare claims submitted by institutional providers, including IRFs. Effective October 1, 2005, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, amended certain sections of the Act to require that Medicare administrative contractors replace fiscal intermediaries by October 2011.

#### **Medicare's Transfer Regulation**

Medicare's transfer regulation distinguishes between discharges and transfers to certain types of facilities. Medicare pays the full prospective payment, based on the case-mix group, to an IRF that discharges a beneficiary to home. In contrast, Medicare pays a lesser amount, based on a per diem rate and the number of days that the beneficiary spent in the IRF, for a transfer case (42 CFR § 412.624(f)). A transfer case is defined as one in which:

- the beneficiary's IRF stay is shorter than the average stay for nontransfer cases in the case-mix group into which the patient falls (42 CFR § 412.624(f)) and
- the beneficiary is transferred to another IRF; a short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments (42 CFR § 412.624(f); 42 CFR § 412.602).

Whether Medicare pays for a discharge to home or a transfer depends on the patient status code indicated on the IRF's claim. IRFs use code 01 to indicate a discharge to home and code 06 to indicate a discharge to home with home health services (*Medicare Claims Processing Manual* (the Manual), ch. 25, § 75.2). CMS specifies that the following patient status codes are subject to the transfer regulation (the Manual, ch. 3, § 140.3; the Manual, ch. 25, § 75.2):

- 02—a short-term, acute-care inpatient hospital;

- 03—a skilled nursing facility;
- 61—a hospital-based, Medicare-approved swing bed<sup>1</sup> within the IRF;
- 62—another IRF;
- 63—a long-term-care hospital; and
- 64—a Medicaid-only nursing facility.

### **Pricing Inpatient Rehabilitation Facility Claims**

To price IRF claims, CMS developed the IRF Pricer program. This program uses information specific to each IRF and information from each claim, including the patient status code, to calculate the price upon which to base the prospective payment.

Claims must indicate the proper patient status codes because the Pricer program uses those codes in determining whether the claims will be paid as discharges or transfers. The Pricer program automatically calculates payments for claims with codes 02, 03, 61, 62, 63, or 64 at the per diem rate for transfers.

### **Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions**

Previous Office of Inspector General audits identified Medicare overpayments that occurred because IRFs did not comply with Medicare’s transfer regulation.<sup>2</sup> In those reports, we recommended that CMS implement edits in the Common Working File (CWF) that match beneficiary discharge dates with admission dates to other providers to identify claims potentially miscoded as discharges rather than transfers. In response to our recommendations, CMS implemented an edit on April 1, 2007 (CMS, Transmittal 1099, Change Request 5354, Attachment – One-Time Notification (Nov. 2, 2006)).

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

### **Objectives**

Our objectives were to determine whether (1) IRFs coded selected claims in compliance with Medicare’s transfer regulation during FYs 2004 through 2007 and (2) the new CWF edit detected miscoded claims and fiscal intermediaries took appropriate action to adjust claims that the edit identified.

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<sup>1</sup> A swing bed is a hospital bed used to provide both long-term care and acute care.

<sup>2</sup> Our previous reports addressed IRF claims coded as discharged to home (report number A-04-04-00008, issued September 11, 2006) and as discharged to home with home health services (report number A-04-04-00013, issued November 2, 2006).

## Scope

Our review covered 5,703 IRF claims totaling \$102,719,261 that were paid from FY 2004 through FY 2007. These claims had shorter than average stays, were coded as discharges to home or discharges to home with home health services, and pertained to beneficiaries who were admitted to another facility on the same day.

We did not review the overall internal control structure of fiscal intermediaries or CMS. We limited our internal control review to obtaining a general understanding of the IRF prospective payment system as it pertained to pricing and paying claims. We accomplished our objectives through substantive testing. We performed fieldwork from November 2008 through August 2009.

## Methodology

To accomplish our objectives, we performed the following procedures:

- We reviewed Federal laws and regulations and CMS guidance concerning IRF transfers.
- We interviewed CMS and fiscal intermediary officials to gain an understanding of how they processed IRF claims and how the CWF edit operated.
- We created a file of nationwide IRF paid claim data for FYs 2004 through 2007 by extracting claims from CMS's calendar years 2003 through 2007 files. The file we created represented \$25 billion in payments for 1,772,771 claims.
- We refined the nationwide file by excluding certain claims, such as claims with lengths of stay equal to or greater than the average length of stay for the case-mix group, outlier claims, claims for deceased beneficiaries, claims not primarily paid by Medicare, and claims paid to Maryland providers.<sup>3</sup>
- From the refined nationwide file, we created a subset file consisting of all claims with status codes "01, discharge to home" and "06, discharge to home with home health services."
- We obtained from CMS files of FYs 2004 through 2007 nationwide Medicare paid claims from the types of facilities subject to Medicare's transfer regulation.
- We matched the subset file of IRF claims against the files of claims from the types of facilities subject to Medicare's transfer regulation. Through this process, we identified 6,702 claims for IRF discharges in which the beneficiary was admitted on the same day to a facility subject to Medicare's transfer regulation, and we created a list of claims potentially miscoded as discharged to home or discharged to home with home health services. These claims constituted our refined population.

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<sup>3</sup> Maryland is exempt from the prospective payment system.

- We excluded 505 claims from the refined population because they lacked certain facility-specific information that would enable us to reprice the claims. We also excluded 494 claims that were canceled or superseded by corrected claims. Removing these 999 claims established our sampling frame of 5,703 claims totaling \$102,719,261 (5,683 claims paid before the CWF edit was implemented and 20 claims paid after the CWF edit was implemented).
- We selected a stratified random sample of 220 claims: 200 claims from the 5,683 claims that were paid before the CWF edit was implemented and all 20 claims that were paid after the CWF edit was implemented.
- We analyzed the CWF claim histories for each of the 220 sampled claims to identify the specific IRF and to determine whether the beneficiary was readmitted to the same IRF and whether the CWF initiated an edit alert for the 20 claims that were paid after the CWF edit was implemented.
- We contacted the 189 IRFs that submitted the 220 sampled claims to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the IRFs agreed that the claims should have been coded as transfers.
- We contacted the 10 fiscal intermediaries that paid the 20 claims after the CWF edit was implemented to determine why the fiscal intermediaries made the payments after receiving CWF edit alerts.
- We repriced each improperly paid claim in our sample to determine the transfer payment amount, compared the repriced payment with the actual payment, and determined the value of the overpayment. Based on the overpayments in our sample, we estimated the dollar value of overpayments to IRFs nationwide.

See Appendix A for details on our sampling methodology and Appendix B for the sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## **FINDINGS AND RECOMMENDATIONS**

IRFs did not always code claims in compliance with Medicare’s transfer regulation. Of the 220 claims in our sample, 7 claims paid after the CWF edit was implemented were not subject to the transfer regulation. The remaining 213 claims, which pertained to transfers to facilities that were subject to the transfer regulation, were improperly coded as discharges. These 213 claims resulted in overpayments of \$1,212,745. Based on our sample results, we estimated that fiscal intermediaries overpaid \$34,051,807 to IRFs for the 4-year period that ended September 30,

2007. IRFs generally attributed the miscoded claims to clerical errors and a lack of knowledge of where beneficiaries went after leaving their facilities.

Although the new CWF edit detected miscoded claims, fiscal intermediaries did not take appropriate action to adjust the claims and prevent incorrect payments. Of the 20 sampled claims that were paid after the CWF edit was implemented, 7 claims were not subject to Medicare's transfer regulation and 13 were incorrectly coded as discharges rather than transfers. The CWF edit detected all 13 incorrectly coded claims. However, fiscal intermediaries did not take action on the CWF edit alerts to prevent incorrect payments for these claims.

## **FEDERAL REQUIREMENTS FOR CODING TRANSFER CLAIMS**

Section 1886(j)(1)(E) of the Act authorizes CMS to adjust a prospective payment to account for the early transfer of a beneficiary from an IRF to another site of care. Implementing regulations (42 CFR § 412.624(f)(1)) require an adjustment to an IRF's prospective payment if the beneficiary's stay in the IRF is shorter than the average stay for nontransfer cases in the given case-mix group and if the beneficiary is transferred from the IRF to another facility specified in 42 CFR § 412.602. The specified facilities include another IRF; a short-term, acute-care prospective payment hospital; a long-term-care hospital; or a nursing home that qualifies for Medicare or Medicaid payments.

Medicare pays the full prospective payment to an IRF that discharges a beneficiary to home. In contrast, pursuant to 42 CFR § 412.624(f)(2), Medicare pays for a transfer case on a per diem basis. CMS calculates the per diem payment rate by dividing the full case-mix-group payment rate by the average length of stay for nontransfer cases in the case-mix group into which the patient falls. CMS then multiplies the per diem rate by the number of days that the beneficiary stayed in the IRF before being transferred. CMS makes an additional half-day payment for the first day.

## **IMPROPER CODING OF TRANSFER CLAIMS**

Of the 220 claims in our sample, 213 pertained to transfers to facilities specified in Medicare's transfer regulation. Contrary to Federal requirements, IRFs coded these claims as discharges rather than transfers. As a result, the IRFs received overpayments of \$1,212,745. Based on our sample results, we estimated that fiscal intermediaries overpaid \$34,051,807 to IRFs for the 4-year period that ended September 30, 2007. IRFs generally attributed the miscoded claims to clerical errors and a lack of knowledge of where beneficiaries went after leaving their facilities.

## **PAYMENT CONTROLS**

For the sampled claims that were paid before April 1, 2007, CMS lacked adequate CWF controls to detect miscoded claims and prevent incorrect payments. CMS responded to recommendations in our previous reports by implementing an edit in the CWF on April 1, 2007. This edit matches the dates of beneficiary discharges from IRFs with admission dates to other providers to identify claims potentially miscoded as discharges rather than transfers. When the edit identifies a

potentially miscoded claim, the CWF alerts the fiscal intermediary to verify the accuracy of the patient status code.

The new CWF edit detected the improperly coded claims in our sample and significantly reduced the number of improperly coded claims paid after April 1, 2007. As shown in Appendix A, the number of claims in our sampling frame with patient status code 01 or 06 that appeared to be transfers decreased from 1,899 in FY 2004 to 655 in FY 2007 (635 before the edit and 20 after the edit). Of the 20 sampled claims paid after the CWF edit was implemented, 7 claims that were not subject to Medicare's transfer regulation appropriately bypassed the CWF edit. Six of the seven claims bypassed the CWF edit because they involved subsequent admissions to critical access hospitals, and one claim involved a subsequent admission that was adjusted and not paid by the fiscal intermediary because the services were not medically necessary.<sup>4</sup> The remaining 13 claims, which were subject to Medicare's transfer regulation, were identified by the CWF edit.

Although the CWF edit detected the 13 incorrectly coded claims, fiscal intermediaries did not take appropriate action in response to the edit alerts generated by the CWF. The fiscal intermediaries informed us that they did not always receive these alerts and did not know that these claims required adjustment. Generally, the fiscal intermediaries attributed this lack of knowledge to the transitioning of claim processing responsibilities from fiscal intermediaries to Medicare administrative contractors.

## **RECOMMENDATIONS**

We recommend that CMS:

- recover the \$1,212,745 in overpayments identified in our sample,
- instruct fiscal intermediaries to review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$32,839,062,
- instruct fiscal intermediaries to take appropriate action in response to future CWF edit alerts,
- follow up with fiscal intermediaries to ensure that they took appropriate action in response to CWF edit alerts, and
- consider reviewing claims paid after our audit period to identify any improperly coded transfers.

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<sup>4</sup> Claims such as this one, which was deemed to be medically unnecessary and coded as a "no pay" claim, appropriately bypass the edit.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In written comments on our draft report, CMS agreed with our recommendations and described the corrective actions that it planned to take. CMS also requested that we furnish the contractor-specific data necessary to recover the overpayments. We provided the data to CMS on May 13, 2010.

CMS's comments are included in their entirety as Appendix C.

# **APPENDIXES**

## APPENDIX A: SAMPLING METHODOLOGY

### POPULATION

The population consisted of nationwide inpatient rehabilitation facility (IRF) claims coded as discharged to home (01) or discharged to home with home health services (06) that appeared to be transfers and were paid during fiscal years (FY) 2004 through 2007 (October 1, 2003, through September 30, 2007).

### SAMPLING FRAME

The sampling frame was a file containing 5,703 IRF claims totaling \$102,719,261 for FYs 2004 through 2007. We divided the sampling frame into five strata based on the FY and the April 1, 2007, effective date of the Common Working File edit:

Stratum	Period	Number of Claims	Dollar Amount
1	Oct. 1, 2003–Sept. 30, 2004	1,899	\$32,108,364
2	Oct. 1, 2004–Sept. 30, 2005	1,685	30,047,987
3	Oct. 1, 2005–Sept. 30, 2006	1,464	27,845,928
4	Oct. 1, 2006–Mar. 31, 2007	635	12,361,336
5	Apr. 1–Sept. 30, 2007	20	355,646
	<b>Total</b>	<b>5,703</b>	<b>\$102,719,261</b>

### SAMPLE UNIT

The sample unit was a paid claim.

### SAMPLE DESIGN

We used a stratified random sample.

### SAMPLE SIZE

We selected 220 claims: 50 claims each from strata 1 through 4 and all 20 claims in stratum 5.

### SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software to generate the random numbers.

### ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the value of overpayments in the sampling frame.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### Sample Results

Stratum	Period	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Improperly Coded Claims in Sample	Value of Overpayments in Sample <sup>1</sup>
1	Oct. 1, 2003–Sept. 30, 2004	1,899	\$32,108,364	50	\$834,130	50	\$306,214
2	Oct. 1, 2004–Sept. 30, 2005	1,685	30,047,987	50	832,553	50	323,944
3	Oct. 1, 2005–Sept. 30, 2006	1,464	27,845,928	50	908,722	50	287,473
4	Oct. 1, 2006–Mar. 31, 2007	635	12,361,336	50	904,116	50	238,682
5	Apr. 1–Sept. 30, 2007	20	355,646	20	355,646	13	56,432
<b>Total</b>		<b>5,703</b>	<b>\$102,719,261</b>	<b>220</b>	<b>\$3,835,167</b>	<b>213</b>	<b>\$1,212,745</b>

### Estimated Value of Overpayments for FYs 2004–2007

*Limits Calculated for a 90-Percent Confidence Interval*

Point estimate	
Stratum 1	\$11,629,989
Stratum 2	10,916,927
Stratum 3	8,417,199
Stratum 4	3,031,260
Stratum 5	56,432
<b>Total</b>	<b>\$34,051,807</b>
Lower limit	
Upper limit	
	\$30,376,892
	37,726,721

<sup>1</sup> We calculated each overpayment by subtracting the payment that should have been made for a transfer from the payment made for a discharge.

**APPENDIX C: CENTERS FOR MEDICARE & MEDICAID SERVICES  
COMMENTS**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** MAY 13 2010

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** *Marilyn Tavenner*  
Marilyn Tavenner  
Acting Administrator and Chief Operating Officer

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Review of Inpatient Rehabilitation Facilities' Compliance With Medicare's Transfer Regulation During Fiscal Years 2004 Through 2007" (A-04-09-00059)

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Thank you for the opportunity to review and comment on the Office of Inspector General's draft report, "Review of Inpatient Rehabilitation Facilities' Compliance With Medicare's Transfer Regulation During Fiscal Years 2004 Through 2007." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which Inpatient Rehabilitation Facilities (IRFs) coded claims in compliance with Medicare's transfer regulation and the extent to which fiscal intermediaries took appropriate action to adjust the claims the new Common Working File (CWF) edit detected.

Medicare pays the full prospective payment to an IRF that discharges a beneficiary to their home. Medicare pays a lesser amount if the beneficiary is considered a transfer case. Previous OIG audits identified this problem and in response, CMS implemented an edit in the CWF on April 1, 2007 to identify transfers improperly coded as discharges.

The CMS will work to improve our oversight of IRF compliance with Medicare's transfer regulation. The OIG made the following recommendations.

**OIG Recommendation 1**

Recover the \$1,212,745 in overpayments identified in our sample.

**CMS Response**

The CMS concurs. CMS agrees that the \$1,212,745 in overpayments should be recovered and CMS plans to recover the overpayments identified. These actions are consistent with the agency's policies and procedures.

The CMS requests that the OIG furnish for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the

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paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, CMS requests that Medicare contractor specific data be written to separate CD-ROMs or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

**OIG Recommendation 2**

Instruct fiscal intermediaries to review the remaining claims in our sampling frame and identify and recover additional overpayments estimated at \$32,839,062.

**CMS Response**

The CMS concurs. Upon receipt of the files from the OIG, CMS will share the OIG report and any additional claims information with the appropriate Medicare contractors and will instruct the Medicare contractors to consider the issues identified in this report and the additional claim information when prioritizing their Medicare review strategies or other interventions. The CMS requests that the OIG furnish the data necessary (provider numbers, claims information including the paid date, HIC #s, Contractor Medicare ID number, Contractor Name, Provider Specialty if applicable, Place of Service Code if applicable, Provider State, and Number of Beneficiaries, etc.) to analyze their data. In addition, CMS also requests all Medicare contract specific data be written to separate CD-ROMs or separate hard copy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

**OIG Recommendation 3**

Instruct fiscal intermediaries to take appropriate action in response to future CWF edit alerts.

**CMS Response**

The CMS concurs. CMS will provide additional contractor education and instruct the fiscal intermediaries (FIs) and Medicare Administrative Contractors (MACs) in the recurring annual update Change Request for the FY 2011 IRF PPS (October 1, 2010), to cancel claims (i.e., recover payment) based on the CWF unsolicited response (i.e., edit alert referred to in the report).

**OIG Recommendation 4**

Follow up with fiscal intermediaries to ensure that they took appropriate action in response to CWF edit alerts.

**CMS Response**

The CMS concurs with the OIG's recommendation. CMS will follow-up with FIs and MACs to ensure appropriate action in response to CWF edit alerts by performing contractor management on-site visits and utilizing our Quality Assurance Surveillance Plan reviews for MACs as needed.

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**OIG Recommendation 5**

Consider reviewing claims paid after the audit period to identify any improperly coded transfers.

**CMS Response**

The CMS concurs. The Recovery Audit Contractors (RACs) review Medicare claims on a post payment basis and are tasked with identifying overpayments and underpayments. While CMS does not mandate areas for RAC review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

The CMS appreciates the OIG's efforts and insight on this report. CMS looks forward to continually working with the OIG on issues related to waste, fraud and abuse in the Medicare program.